CHAPTER I: OVERVIEW OF PPS FOR INPATIENT REHABILITATION FACILITIES

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OBJECTIVE

This chapter provides participants with an overview of the prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital. It also introduces terminology and concepts that will facilitate understanding of the detailed discussion in later chapters.

Initial Medicare Statute Medicare Payment based on Reasonable Costs

TEFRA Provided Cost-Per-Discharge Limitation

Social Security Amendments of 1983 Established Prospective Payment System for Most Hospital Inpatient Services (Excluded Inpatient Rehabilitation)

Number of IRFs and Payments Drastically Increased

BBA and BIPA Provided for Implementation of Inpatient Rehabilitation Facility Prospective Payment

- **Initially to be Implemented for Cost Reporting Periods Beginning on or After 10/1/2000**
- **Revised Implementation for Cost Reporting Periods Beginning on or After 1/1/2002**

BACKGROUND

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248) to limit payment by placing a limit on allowable costs per discharge. Section 601 of the Social Security Amendments of 1983 (Public Law 98–21) added a new section 1886(d) to the Act that replaced the reasonable cost-based payment system for most hospital inpatient services. That section of the Act provides for a prospective payment system for the operating costs of hospital inpatient stays effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although most hospital inpatient services became subject to a prospective payment system, certain specialty hospitals were excluded from that system. Inpatient rehabilitation hospitals and distinct part rehabilitation units in hospitals were among the excluded facilities.

Subsequent to the implementation of the hospital inpatient prospective payment system, both the number of excluded facilities, particularly distinct part units, and Medicare payments to these facilities grew rapidly. In order to control escalating costs, the Congress, through enactment of section 4421 of the BBA, section 125 of the BBRA, and section 305 of the BIPA, provided for the implementation of a prospective payment system for inpatient rehabilitation facilities (IRFs).

The statute provided for the prospective payment system for IRFs to be implemented for cost reporting periods beginning on or after October 1, 2000. However, because of the extensive changes required by the statute to change the payment systems for IRFs as well as the demands of simultaneously implementing new prospective payment systems for

outpatient hospital and home health services, CMS determined that it was not feasible to implement the IRF prospective payment system as of October 1, 2000. After an extensive analysis of the changes required to both the providers' and intermediary systems, CMS has determined that the earliest feasible date to implement the IRF PPS is for cost reporting periods beginning on or after January 1, 2002.

Classification as IRF

- **Unchanged from Requirements for Exempt Entities**

Specific Entities Excluded from IRF PPS

- **Veteran's Hospitals**
- **Hospitals Reimbursed under State Control Systems**
- **Some Demonstration Providers**

INPATIENT REHABILITATION CLASSIFICATION REQUIREMENTS

In general, the criteria for a facility to be classified as an IRF remains unchanged from the requirements used to classify entities as exempt from the acute care hospital PPS. In order to be paid under the IRF PPS, a facility first must meet the conditions for payment under section 412.604 of the regulations. In addition, an entity must meet the requirements under section 412.23(b) which in part states that a facility must:

> "show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, polyarthritis (including rheumatoid arthritis), neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease), and burns."

Hospitals that are not paid under the IRF PPS, but are paid under special payment provisions are: Veteran's Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public

Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1).

MEDICARE INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF PAI)

Patient Assessment Instrument

- **Beginning 1/1/2002 for Medicare Part A FFS Patients**
- **At Admission and Discharge**
- **Software Provided to Facilities**

IRF PPS payment is contingent upon an IRF completing an IRF PAI and transmitting the IRF PAI data to CMS. The IRF PAI must be completed on Medicare Part A fee-for-service patients upon the patient's admission and discharge, with the admission and discharge data transmitted together and only one time after the patient has been discharged.

Beginning on January 1, 2002, for Medicare Part A fee-for-service patients, IRFs must collect patient assessment data using the CMS IRF patient assessment instrument (PAI) as part of the IRF's inpatient assessment process. This data collection requirement applies to Medicare beneficiaries who are already inpatients as of January 1, 2002, as well as beneficiaries admitted as inpatients on or after January 1, 2002, regardless of the IRFs cost reporting beginning dates. The IRFs must encode the patient assessment data by entering the data into a computer software program that will be provided at no charge to IRFs. CMS will make the software available at its website at www.hcfa.gov/medicare/irfpps.htm.

Patient Assessment Instrument

- **Admission PAI Used to Classify Patient into CMG**
- **Discharge PAI Used to Determine Comorbidities**

Assessment Schedule Published in Final Rule

PAI Guide to be Provided

The admission patient assessment will be used to classify each Medicare Part A fee-for-service patient into a CMG, and the CMG will be used to determine the IRF payment. While the admission assessment is used to place a patient in a CMG, the discharge assessment is used to determine the relevant weighting factors, if applicable, associated with comorbidities.

The final rule contains detailed information regarding the assessment schedule for the PAI with respect to transmission requirements, encoding dates, and other pertinent information. CMS will provide a guide, which will include detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Case-Mix Groups

- **Rehabilitation Impairment Categories**
- **Motor/Cognitive/ Age**

(Table 1)

Comorbidities

- **Three Tiers**

(Appendix C)

CASE MIX GROUP CLASSIFICATION SYSTEM

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. The Final Rule used Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are formed using codes from the International Classification of Diseases 9th Revision Clinical Modifications (ICD-9 CM codes). In addition to the RICs, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age also allows CMS to improve the explanatory power of the CMGs if they split some of the groups based on this variable. Lastly, comorbidites were found to substantially increase the average cost of specific CMGs. The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

100 Distinct CMG Payment Rates

- **Standard Payment Amount/Budget Neutral Conversion Factor**
- **Relative Payment Weights**
- **Standardized for Facility Level and Case Level Adjustments**

PAYMENT RATES

The IRF prospective payment system utilizes federal prospective payment rates across 100 distinct CMGs. The federal payment rates are established using a standard payment amount (referred to as the budget neutral conversion factor). A set of relative payment weights that account for the relative differences in resource use across the CMGs is applied to the budget neutral conversion factor and, finally, a number of facility-level and case-level adjustments may apply. The facility-level adjustments include those that account for geographic variation in wages (wage index), percentage for low income patients (LIP) and location in a rural area. Case-level adjustments include those that apply for interrupted stays, transfer cases, short stays, cases in which patients expire and outlier cases.

CMG Relative Weights Basis:

- **Costs from FY 96-98 Cost Reports**
- **Charges from CY 99 Bill Data**
- **Further Adjusted for Comorbidity**
- **Excluded All-inclusive Providers**

CMG Relative Weights

Relative weights were calculated using cost report data from fiscal year 1998, 1997 and 1996, charge data was obtained from calendar year 1999 Medicare bill data and functional measures were derived from the FIM data. Data was omitted from rehabilitation facilities that are classified as all-inclusive providers from the calculation of the relative weights, because these facilities are paid a single, negotiated rate per discharge and they do not maintain a charge structure. Calculated relative weights were further adjusted to reflect the comorbidity tiers, identified in the final rule.

Payment Adjustments

- **Area Wage Variations**
- **Facilities Located in Rural Areas**
- **Outlier**
- **Low Income**

Payment Adjustments

Federal prospective payment amounts will be adjusted to account for geographic area wage variations, outlier cases, facilities located in rural areas and to reflect the percentage of low income patients.

Budget Neutral Conversion Factor

- **100% of Federal Fiscal Year 2002 Expenditures**

Budget Neutral Conversion Factor

The BBA specifies that payments during federal fiscal years 2001 and 2002 must be established in a manner that results in the amount of total payments, including any adjustments, being equal to 98 percent of the amount of payments that would have been made during those fiscal years (for operating and capital costs) had the IRF PPS not been enacted. However, as a result of the implementation of BIPA, a change has been made to eliminate the reduction factor. Under section 305 of the BIPA 2000, section 1886(j)(3)(b) of the Act is amended to increase the amount of payment to 100 percent of FFY 2002 expenditures.

Federal CMG Payments

- **8/7/2001 Federal Register**
- **Updated to be Published Prior to August 1 of Preceding Year**

Federal CMG Prospective Payments

For the initial period of PPS, (for cost reporting periods beginning on or after January 1, 2002 and before Oct. 1, 2002) all payment rates and associated rules were published in the *Federal Register* on August 7, 2001. For each succeeding fiscal year, the rates will be published in the *Federal Register* on or before August 1 of the year preceding the affected fiscal year.

CASE-LEVEL ADJUSTMENTS

Payment will be based on the CMGs described above, as well as possible adjustments specific to the case and the facility characteristics. More than one case level adjustment may apply to the same case. Thus, for ease of understanding we present the discussion of the case-level adjustments in the same order that will be used to assess whether or not they apply. For instance, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

Interrupted Stays

Interrupted Stay

- **Discharged and Returns Within 3 Consecutive Days**
- **LOS Includes Days Prior to Interruption and Days After**
- **Payment Based on Initial Assessment**

Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the IRF and returns to the same IRF within three consecutive calendar days. The three consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption. One CMG payment will be made for these cases and the payment will be based on the initial assessment.

Transfer Cases

- **Transferred AND LOS less than Average LOS for CMG**
- **Per-Diem Payment**
- **First Day Receives Additional ½ Payment**

Transfer Cases

For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Transfer cases will be paid on a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

Short Stay Cases

- **LOS 3 Days or less**
- **Separate CMG Payment**
- **Includes Cases That Expired in 3 Days or less**

Expired Cases LOS Greater than 3 Days

- **Separate CMG Payments**
- **Four CMG Groups**

Short-Stay Cases

The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of three days or less, without consideration of the clinical characteristics of the patient. Further, cases that expire with a length of stay of three days or less will also be classified to CMG 5001.

Expired Cases

Separate CMGs will also be made for cases that expire with a length of stay greater than three days. To improve the explanatory power of the groups, CMS created four additional CMGs to account for cases that expire. CMG 5101 will be used for short-stay, orthopedic, expired cases. This CMG includes those cases that would otherwise be grouped to RICs 07, 08, and 09 and the length of the stay is greater than three days, but less than or equal to 13 days. CMG 5102 will be used for orthopedic expired cases

where the length of stay is greater than or equal to 14 days. CMG 5103 will be used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than three days, but less than or equal to 15 days. CMG 5104 will be used for non-orthopedic expired cases where the length of stay is greater than or equal to16 days.

FACILITY-LEVEL ADJUSTMENTS

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for facilities located in rural areas, and an adjustment for treating low-income patients. Outlier payments will also be discussed in this section. Although outlier payments are considered to be a case-level adjustment, a case can only be determined to qualify for these additional payments after all other facility-level adjustments are computed. Thus, for ease of understanding we present the discussion of these facility-level and outlier adjustments in the same order that will be used to assess their applicability.

Area Wage Adjustment

- **Labor Related Portion 72.395%**
- **Inpatient Acute Care Hospital Wage Data**
- **Excludes Teaching Physicians, I&Rs and CRNAs**
- **Excludes Geographic Reclassifications**

Area Wage Adjustment

To adjust payments for area wage differences, the excluded hospital market basket with capital costs was analyzed to identify the labor-related portion of the prospective payment rates. The labor-related portion has been determined to be 72.395 percent and the non-labor related portion is 27.605 percent. The labor-related unadjusted federal payment is multiplied by a wage index value to account for area wage differences. The inpatient acute care hospital wage data will be used to compute the wage indices. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare Part B, because these services are not covered under the IRF PPS. The wage index that will apply to the IRF PPS payment rates excludes 100

percent of wages for teaching physicians, residents, and nonphysician anesthetists. IRFs will be divided into labor market areas. As with other CMS payment systems, we define an urban area as a Metropolitan Statistical Areas (MSAs) or New England County Metropolitan Areas, as defined by the Executive Office of Management and Budget. For the purposes of computing the wage index for IRFs, the wage index values for urban and rural areas are determined without regard to geographic reclassification.

Adjustments for Rural Location

Payments will also be adjusted for facilities located in rural areas. A facility will be considered to be a rural IRF if it is located in a non-MSA area. Payments to rural IRFs will be multiplied by 1.1914.

Adjustment for Percentage of Low Income Patients

Additional payments will be made for treating low income patients (LIP). There are two parts in computing this adjustment. The first is the calculation of the disproportionate share variable (DSH). This is computed by:

$$DSH = \frac{\text{SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

Once the DSH is calculated, this percentage is used to determine the LIP adjustment. Each IRF payment will be multiplied by the following formula to account for the cost of furnishing care to low income patients:

[1+DSH] raised to the power of .4838

Cost Outliers

Additional payments will be made for those cases that are high cost outliers. A case will be considered to be an outlier if the estimated cost of the case exceeds an

- **Unadjusted Threshold Amount $11,211**
- **Cost Outliers - Estimated Cost of the Case Exceeds the Sum of the Adjusted Threshold Amount and the Adjusted CMG Payment**
- **Outlier Payment at 80% of Difference**

adjusted threshold amount. The estimated cost of the case will be calculated by multiplying the charge by the facility's overall cost-to-charge ratio obtained from the latest settled cost report. If the estimated cost of the case is greater than the sum of the adjusted payment amount and the adjusted threshold amount, then the case is considered an outlier and additional payments will be added to the adjusted payment amount. The outlier payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the facility-level adjusted CMG payment and the threshold amount multiplied by the facility-level adjustments as described above). The unadjusted threshold amount as determined in the final rule is $11,211.

Phase-In

- **Initially 66 2/3% PPS and 33 1/3% TEFRA**
- **May Elect 100% PPS**

PHASE-IN IMPLEMENTATION

Under the BBA, the federal fiscal year in which a facility's cost reporting period begins, determines which transition period percentages apply. The first transition period percentages were to be applicable for cost reporting periods beginning during federal fiscal year 2001. The second transition period percentages were to be applicable to cost reporting periods beginning during federal fiscal year 2002, that is, periods beginning on or after October 1, 2001 and before October 1, 2002. For cost reporting periods beginning during federal fiscal year 2003 and after, payment is based on 100 percent of the adjusted federal prospective payment.

As the IRF PPS is being implemented for cost reporting periods beginning on or after January 1, 2002, IRFs will be phased directly into the second transition period, where payment will be based on 66 2/3% of the PPS payment and 33 1/3% of the TEFRA payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its entire cost reporting period beginning prior to January 1, 2002.

In addition, section 305 of the BIPA 2000 states facilities may elect to be paid 100% PPS payment, rather than payment based on the transition method.

If a facility chooses not to be paid under the transition method, it must notify its fiscal intermediary (FI) no later than 30 days prior to its first cost reporting period for which the IRF PPS applies to the facility. The request to make the election must be made in writing to the FI for the facility. The FI must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period falls on a day that the postal service or other delivery sources are not open for business, the facility is responsible for allowing sufficient time for delivery of the request before the deadline. If a facility's request is not received or not approved, payment will be based on the transition method.

PAYMENTS TO PROVIDERS

IRF PPS does not preclude the continuation of PIP. For those services paid under the PIP method, the amount reflects the estimated prospective payments for the year rather than estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in section 412.632 and receives approval by its FI. Similarly, if an intermediary determines that an IRF that received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in section 412.632, FI approval of a PIP is conditioned upon the FI's best judgment as to whether making payment under the PIP method would not entail undue risk of resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the IRF prospective payment system, including Medicare bad debts, costs of an approved

educational program and blood clotting factors provided to Medicare inpatients who have hemophilia, will be subject to the interim payment provisions of the existing regulations at section 413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method, it may qualify to receive an accelerated payment. Under section 412.632, the IRF must be experiencing financial difficulties due to a delay by the FI in making payment to the IRF, or there is a temporary delay in the IRF's preparation and submittal of bills to the FI beyond its normal billing cycle because of an exceptional situation. The IRF must make a request for an accelerated payment, which is subject to approval by the FI and by CMS. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment occurs as bills are processed or through direct payment by the IRF.

BENEFICIARY LIABILITY

Beneficiary liability will operate the same as under the TEFRA payment system. Even if Medicare payments are below the cost of care for a patient under prospective payment, the patient cannot be billed for the difference in any case.

BILLING CHANGES

IRFs will be required to modify billing procedures effective for cost reporting periods beginning on or after January 1, 2002. Generally, these billing changes are required to:

- Indicate that payment will be made under IRF PPS
- Indicate the appropriate CMG and comorbidity for payment
- Indicate expired cases

- Indicate dates of service for the determination of transfer cases, interrupted stays or short stays

- Indicate covered charges for the outlier calculation

Billing changes will also be required to accommodate patients with stays that straddle the provider's implementation date.